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INTERNAL CONTROLS

Need to Strengthen Controls Over Payments by Medicare Intermediaries

GAO

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The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Jack Brooks
Chairman, Committee on
Government Operations
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

This report discusses problems the Health Care Financing Administration is experiencing in resolving claims processing errors related to Medicare payments to institutions and the need for it to make better use of the results of external reviews in managing the program. A number of the problems we found stemmed from internal control weaknesses. We believe these weaknesses should have been reported by the Secretary of Health and Human Services to the President and the Congress under the requirements of the Federal Managers' Financial Integrity Act of 1982.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Administrator of the Health Care Financing Administration; and other interested parties.

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Medicare spent about $56 billion in fiscal year 1987 for services provided by hospitals and other institutions. GAO reviewed the effectiveness of the internal controls that program managers use for assuring that services provided are of acceptable quality and that payments to them are (1) accurate, (2) for patients entitled to benefits, and (3) for services covered by Medicare.

Background

Health insurance companies, under contract with the government, process and pay Medicare claims. Agents that pay claims from institutions are referred to as intermediaries; those that pay claims from physicians and other noninstitutional providers are referred to as carriers. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is responsible for contracting with and monitoring the performance of intermediaries and carriers.

To assure the propriety of benefit payments by the intermediaries, HCFA has established key internal controls. The HCFA Central Office (1) maintains a master record of claims paid on behalf of each Medicare beneficiary and (2) performs a series of computer edits to detect cases where errors in processing claims may have occurred.

To determine the necessity, appropriateness, and quality of inpatient hospital services, peer review organizations (PROs), under contract with HCFA, preapprove certain nonemergency hospital admissions and review supporting documentation for selected paid claims. A research consulting firm, also under contract with HCFA, known as SuperPRO, reviews the adequacy of the PROs' reviews. In addition, HCFA monitors intermediary and PRO performance.

Results in Brief

HCFA has not assured that intermediaries resolve potential claims processing errors identified by master record computer edits. This has resulted in a backlog of over 2 million unresolved errors as of July 1987. In reviewing 277 of these potential errors, GAO found 73 overpayments totaling $272,011 and 7 underpayments totaling $5,468. The remaining 197 cases generally involved errors that had no effect on the payments reviewed. (See ch. 2.)

HCFA does not effectively use SuperPRO findings to identify and correct systemic problems that allow such significant numbers of errors to occur. Using the results of SuperPRO evaluations covering 3 of 44 PROs for periods of about 15 months ended in 1986, GAO projected that the 3 PROs

had allowed millions of dollars in overpayments and underpayments. Specifically, the PROs did not detect about 43,000 unnecessary hospital admissions, and allowed payments for about 38,000 incorrectly categorized diagnoses. The PROs also failed to detect about 12,000 cases where the quality of care did not meet minimum acceptable professional standards. (See ch. 3.)

The three intermediaries GAO reviewed had developed various computer edits to identify claims for medical services that may have been unnecessary. However, the number and types of edits varied substantially, and the intermediaries had not analyzed the usefulness of each of the edits. HCFA requires that such information be collected by carriers but does not have a similar requirement for intermediaries. On the basis of information from the nation's carriers, HCFA identified certain edits for all carriers to use when processing claims for services by physicians and other noninstitutional providers. These edits resulted in $67.4 million in disallowed claims during the first half of fiscal year 1987. (See ch. 4.)

Principal Findings

Need to Assure Resolution of Claims Processing Errors

Cases with high potential for error that had been identified by master record computer edits were generally not resolved. The average age of such cases in HCFA's inventory was 393 days as of April 1987. In March 1988, HCFA purged its inventory of over a million of the cases and does not plan to assure that errors in the purged cases are resolved. Data developed by GAO showed that many of the purged cases involved significant erroneous payments. (See pp. 16 to 24.)

GAO reviewed claims identified by 13 of HCFA's approximately 160 master record computer edits to ascertain the incidence and significance of errors, and corrective action by intermediaries. Twelve of these edits identified the type of errors that had to be returned to intermediaries for resolution. As of November 30, 1986, HCFA files contained 543,000 of these unresolved errors in payments totaling $1.6 billion. GAO analyzed data on 59 cases totaling $557,738 and found 35 overpayments totaling $106,156 and 7 underpayments totaling $5,468. (See pp. 15 to 22.)

GAO also reviewed the edit used to identify possible duplicate payments by examining 218 claims for payments totaling $654,672, selected from 20,285 duplicate claims the edit detected over 3 months. GAO found that

180 claims were incorrectly classified as duplicate claims primarily because of problems in communicating claims data from intermediaries to HCFA. The remaining 38 claims involving payments totaling $165,855, or 25 percent of the amount reviewed, were paid in duplicate. The intermediaries had resolved 16 of the 38 duplicate payments. However, GAO believes that timely follow-up on notifications from HCFA of possible duplicate payments could have resulted in the resolution of all 38 cases. (See pp. 18, 19, 21, and 22.)

More Effective Use of SuperPRO Needed

About every 6 months, SuperPRO evaluates 400 randomly selected claims reviewed by each PRO. Data compiled by HCFA as of January 1988 showed that SuperPRO consistently identified about three times as many incorrectly categorized diagnoses, about four times as many instances of questionable hospital admissions, and more than twice as many cases of poor quality care as did the nation's PROs. (See pp. 30 to 32.)

Even though SuperPRO's findings are significant, HCFA makes little use of the results in assuring that the causes of erroneous PRO decisions are identified and corrected. There is also no process for resolving disagreements between SuperPRO and PROs. In addition, in those cases where PROs agreed that an error was made, erroneous payments identified by SuperPRO were not adjusted. (See pp. 32 to 34 and 36 and 37.)

Through its monitoring programs, HCFA also evaluates PRO decisions. Some of these decisions are also subject to evaluation by SuperPRO. Rather than duplicating the work of SuperPRO, GAO believes the HCFA medical staff could be more effectively used to assure that the causes of erroneous PRO decisions found by SuperPRO are identified and corrected. (See pp. 35 and 36.)

Need to Strengthen Internal Controls

Based on the success HCFA has had in using reports from carriers on the effectiveness of their edits, GAO believes that substantial savings can be achieved by undergoing a similar process to assure that all intermediaries are using the most effective medical need edits. (See pp. 42 and 43.)

The potential for use of SuperPRO as a control over the quality of PRO reviews is diminished because PROs have the opportunity to reconsider and change their review decisions after they are notified of the cases selected for SuperPRO review. This raises questions about the validity of

using SuperPRO results as a measure of PRO performance. (See pp. 43 to 44.)

Reporting Under FMFIA

The internal control weaknesses GAO identified were not included by HCFA program managers in their evaluations under the Federal Managers' Financial Integrity Act (FMFIA). These identified weaknesses also were not included in the Secretary of HHS's fiscal year 1987 FMFIA report to the President and the Congress.

GAO's report discloses weaknesses in key controls over Medicare payments nationwide that involved significant amounts of inappropriate payments and failure to detect poor quality care. GAO believes that such weaknesses are material and should be reported under FMFIA. (See pp. 15, 25, 27 to 29, 38, 40, 42, 45, and 46.)

Recommendations

To more adequately assure the appropriateness of Medicare payments to institutions, GAO recommends that the Secretary of HHS (1) make more effective use of internal controls in operation and (2) strengthen other controls.

GAO is also recommending that the Secretary of HHS, in the Department's fiscal year 1988 FMFIA report, include a discussion of (1) the material internal control weaknesses identified in this report and (2) the planned or completed actions to correct them. (See pp. 25, 38, 39, and 45.)

Agency Comments

HHS said it was addressing or considering acting on some of GAO's recommendations but disagreed with or otherwise indicated it would not act on a number of others. GAO's evaluations of HHS's comments are included on pages 25 to 28, 39 to 41, and 45 and 46, and the Department's comments are included in appendix II.

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Abbreviations

CPEP	Contractor Performance Evaluation Program
DRG	diagnosis related group
FMFIA	Federal Managers' Financial Integrity Act of 1982
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
PPS	Prospective Payment System
PRO	peer review organization
PROMPTS	PRO Monitoring Protocol and Tracking System
RTI	returned to intermediary
SuperPRO	firm that checks the quality of PRO reviews
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Chapter 1

Introduction

Our report involves a study of the effectiveness of internal controls that federal managers use for assuring that payments by Medicare intermediaries are made in accordance with federal laws and are adequately safeguarded against fraud, waste, and abuse. Intermediaries are the Health Care Financing Administration's (HCFA's) Medicare agents that pay for services provided primarily by hospitals and other institutional providers. Organizations that pay for services provided by physicians and other noninstitutional providers are called carriers. This report focuses on HCFA's controls over intermediaries.

Payments by Medicare intermediaries totaled about $55.8 billion in fiscal year 1987. Most of this amount, about $45.3 billion, went to pay for inpatient hospital services. Another $5.5 billion went for outpatient hospital services; most of the remaining $5 billion went for care provided by home health agencies and skilled nursing facilities.

Agency heads are required by the Accounting and Auditing Act of 1950 to establish and maintain effective systems of internal control. The Federal Managers' Financial Integrity Act of 1982 (FMFIA) places with management the primary responsibility for adequate internal control systems. FMFIA requires that agency heads report annually to the President and the Congress on the status of these systems and for disclosure and correction of material internal control weaknesses.

Internal controls are an integral part of systems that managers use to guide their operations. They include an agency's organization and methods and procedures used to ensure that (1) resource use is consistent with laws, regulations, and policies; (2) resources are safeguarded against waste, loss, and misuse; and (3) reliable data are obtained, maintained, and fairly disclosed in reports. An effective internal control system[1] provides reasonable assurance that:

- internal control responsibilities are assigned to competent managers and employees who have a good understanding of and supportive attitude toward internal controls;
- transactions and other significant events are (1) authorized and executed only by persons acting within the scope of their authority and (2) properly recorded;
- key duties and responsibilities in authorizing, processing, recording, and reviewing transactions are separated;
- access to resources and records is limited to authorized individuals;

[1]See Standards for Internal Controls in the Federal Government, accounting series, GAO, 1983.

- accountability for the custody and use of resources is assigned and maintained;
- audit findings are promptly resolved; and
- there is qualified and continuous supervision to ensure that internal control objectives are achieved.

Background on the Medicare Program

Medicare pays much of the health care costs for eligible people aged 65 or older and for some of the disabled. It provides two basic forms of protection:

- Part A, Hospital Insurance, financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities, and care provided in patients' homes and by hospices.
- Part B, Supplementary Medical Insurance, a voluntary program financed by enrollee premiums and federal contributions, covers physician and outpatient hospital services and many other health services, such as laboratory and physical therapy services.

About 90 percent of the payments for services provided to hospital inpatients are made under the Prospective Payment System (PPS). Under PPS, hospitals receive payments based on predetermined rates for 475 different groupings of diagnoses and procedures, referred to as diagnosis related groups (DRGs).

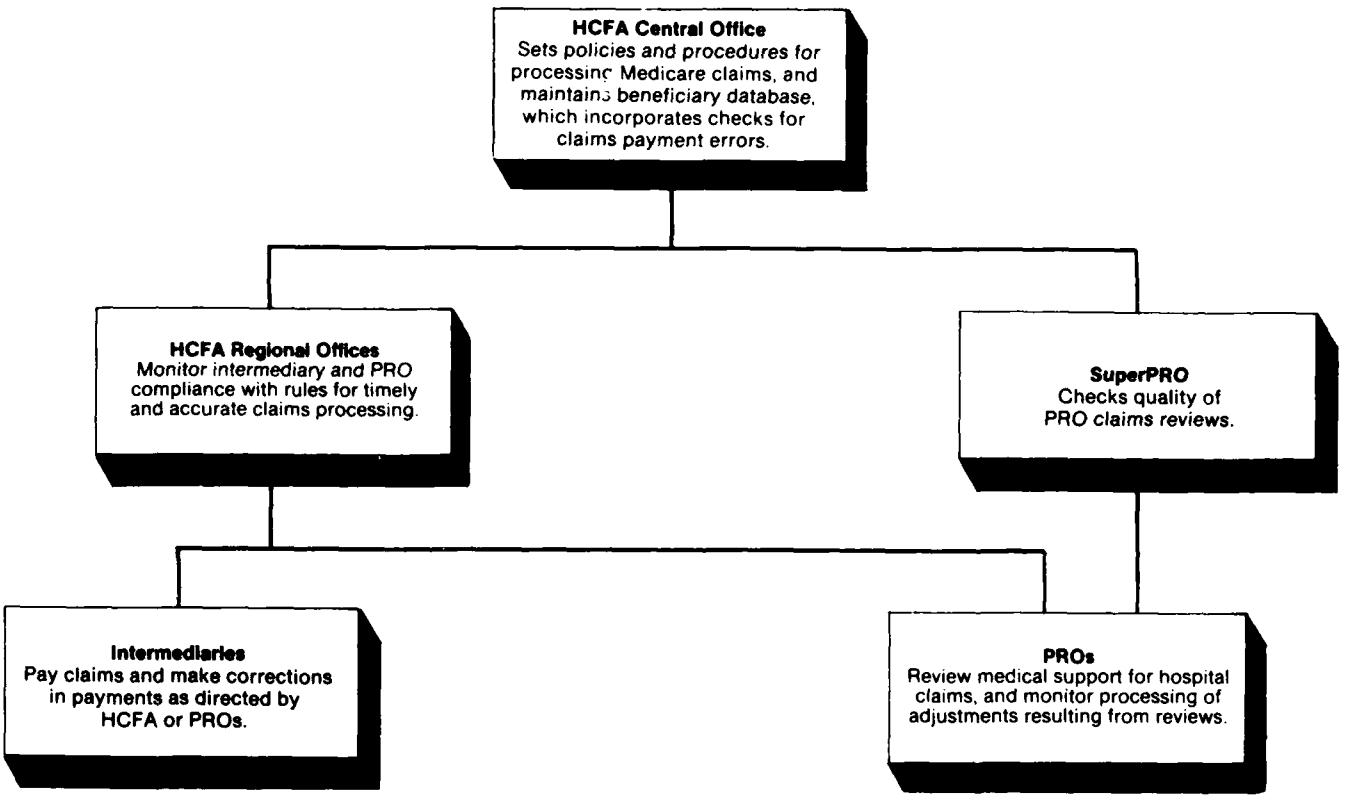
Within the Department of Health and Human Services (HHS), HCFA is responsible for the overall administration of Medicare, including establishing regulations and policies under which the program operates. One of HCFA's primary responsibilities is contracting with intermediaries and monitoring their performance.

Key Organizational Controls

Several organizations have key responsibilities for assuring the propriety of benefit payments by the intermediaries. HCFA maintains a master record of claims paid on behalf of each Medicare beneficiary and uses a series of computer edits to detect payment errors. Medical review organizations (known as peer review organizations [PROs]), under contract with HCFA, (1) preapprove certain nonemergency cases and (2) review supporting documentation for selected paid claims to determine the necessity, appropriateness, and quality of inpatient hospital services received by Medicare beneficiaries. Also under contract with HCFA, a research consulting firm specializing in health care data analysis (known as SuperPRO) reviews the adequacy of PRO reviews. In addition,

incorporated into HCFA's programs are procedures for monitoring intermediary and PRO performance. Organizations with key responsibilities for assuring the propriety of benefit payments by intermediaries are shown in figure 1.1.

Figure 1.1: Key Organizational Controls Over Medicare Payments by Intermediaries



Intermediaries

Intermediaries are responsible for processing and paying all part A claims, communicating with providers about the Medicare program and changes to it, and providing other related administrative services. In June 1988, Medicare had intermediary contracts with seven commercial insurance companies and the Blue Cross and Blue Shield Association

(which, in turn, subcontracts with 45 local Blue Cross plans). The vast majority of providers deal with the local Blue Cross plans.

In receiving, processing, and paying claims from institutional providers, intermediaries are responsible for (1) checking the completeness of the claims, (2) checking the Central Office master record or otherwise verifying patient entitlement to services provided, (3) assuring that medical services have been preapproved where required, (4) reporting to HCFA on claims that are paid, (5) assuring the propriety of provider cost reports, and (6) adjusting provider payments for the results of audit and other postpayment review determinations. Intermediaries are also responsible for assuring that services provided (except for hospital inpatient services) were covered by Medicare and were medically necessary.

Peer Review Organizations

HCFA contracts with 44 PROs throughout the nation to evaluate documentation supporting claims for payment of hospital inpatient services. The PROs conduct postpayment reviews of hospital records and other documentation supporting selected inpatient hospital claims. PROs determine whether (1) the admission was necessary, (2) the claim was classified into the appropriate DRG, (3) any unusually high costs or long lengths of stay were justified,[2] and (4) the services provided met minimum acceptable quality standards.

The PROs report payment irregularities to the intermediaries who, in turn, recover from hospitals payments for unnecessary admissions or other overpayments, or make additional payments where there were underpayments. PROs monitor corrective action data submitted by the intermediaries, and report to HCFA on the timeliness of the corrective actions as reported by the intermediaries. PROs are also responsible for (1) identifying providers that repeatedly submit inappropriate claims or provide substandard services, (2) encouraging providers to correct their practices, and (3) recommending to HHS that sanctions be imposed on providers where sustained serious or gross violations have occurred. In addition, PROs preapprove the need for cataract extractions and certain other nonemergency hospital procedures or admissions.

[2]Medicare law and regulations provide that a hospital can be compensated for more than is allowed by established PPS rates for a case requiring substantially higher costs or a much longer length of stay than normally expected for the DRG into which a claim is classified.

Review of PROs

HCFA contracts with SuperPRO to evaluate the adequacy of PRO reviews. SuperPRO assesses the accuracy of decisions by the nation's PROs concerning the necessity of inpatient care, DRG classifications, and quality-of-care issues. Reports from SuperPRO summarize cases where there is disagreement with PRO decisions.

HCFA Oversight

HCFA establishes guidelines for reviews conducted by intermediaries and PROs. For PPS payments, HCFA (1) developed the formulas and computer programs used by intermediaries in computing PPS payments and (2) provided most of the data used in making the computations. HCFA also maintains a master record of all claims paid on behalf of Medicare beneficiaries. Intermediaries check this record to determine deductibles and remaining benefit entitlement.[3] Intermediaries then report paid claims to HCFA for entry into the master record. Before recording data from claims into the master record, HCFA performs computer edits to detect errors made in paying the claims and notifies intermediaries of the errors detected. In addition, HCFA's regional offices monitor the intermediaries' and PROs' compliance with rules for timely and accurate claims processing.

HCFA, in carrying out its oversight responsibilities, has developed 11 monitoring programs.[4] Two of the key programs are the Contractor Performance Evaluation Program (CPEP), for evaluating intermediary performance, and the PRO Monitoring Protocol and Tracking System (PROMPTS), for monitoring PRO performance. Under its monitoring programs, HCFA (1) reviews intermediaries' and PROs' processes for selecting the claims to be medically reviewed, (2) conducts tests to assess the appropriateness of decisions made by intermediary and PRO medical reviewers, (3) tests selected PPS payments for the appropriateness of DRG groupings and payment calculations, and (4) evaluates the appropriateness of the intermediaries' rationale for making reimbursement decisions by reviewing selected cost reports submitted by institutions.

In addition to intermediary and PRO monitoring programs, HCFA also oversees state health departments' compliance with federal inspection guidelines for institutional providers' facilities. The inspection results

[3]For fiscal year 1987, the patient was responsible for $520 of costs covered by part A for every inpatient stay separated by more than 60 days, as well as some or all costs involving stays exceeding 60 days.

[4]Appendix I describes HCFA's intermediary and PRO monitoring programs.

are used as a basis for determining whether an institution is capable of caring for Medicare beneficiaries.

Objective, Scope, and Methodology

Our objective was to determine whether HCFA's system of internal controls over Medicare payments for services by institutional providers provided reasonable assurance that the following key internal control objectives we identified from Medicare law and regulations were met.

- The patients were entitled to Medicare benefits.
- The services were provided as claimed, covered by Medicare, medically necessary, and of acceptable quality.
- Amounts paid were reasonable.
- Settlements were made correctly.

We also assessed whether program managers were adequately (1) identifying material weaknesses in HCFA's system of internal controls and (2) including the weaknesses and planned corrective actions in the Secretary's annual report to the President and the Congress as required by FMFIA.

We identified HCFA's organizational structure, monitoring programs, and other procedures used to assess controls over payments by Medicare intermediaries. We also discussed HCFA's methods for assuring the propriety of benefit payments with Central Office and regional officials, and evaluated HCFA regional office and contractor techniques for achieving the key benefit payment control objectives we had identified from reviewing the Medicare law and regulations. Where we judged the techniques to be inadequate, we performed tests and evaluations to determine the benefits that would be derived from improving them. For example, we

- selected examples of the types of claims processing errors, in consultation with HCFA officials, identified by HCFA's master record computer edits that raise the most serious payment questions. We determined what intermediaries had done to correct the errors and the monetary effect of correcting them.
- evaluated (1) the adequacy of SuperPRO sampling methodology and other review methods, (2) national summaries of SuperPRO results, (3) all SuperPRO reports available at the time of our field work for the three PROs we reviewed, and (4) differences between SuperPRO and PRO case review

results. We also discussed with PRO and HCFA personnel their use of SuperPRO results to assure that the causes of erroneous review decisions are identified and corrected.

- evaluated the types of case reviews performed by HCFA medical personnel and their use of SuperPRO results in these reviews.
- obtained and compared information from the three intermediaries in our review on the number and types of edits each one used to detect claims for services that may not have been medically necessary.

We performed our review from April 1986 through December 1987, in accordance with generally accepted government auditing standards.

Locations of Audit Work

Our work was done at the HCFA Central Office in Baltimore; at 3 of the 10 HCFA regional offices—Atlanta, Chicago, and San Francisco; and at the following contractor locations:

- SuperPRO—SysteMetrics, Inc., Santa Barbara, California.
- Intermediaries—Blue Cross of California, Woodland Hills, California; Blue Cross and Blue Shield of Florida, Inc., Jacksonville, Florida; and Health Care Service Corporation (Blue Cross of Illinois), Chicago, Illinois.
- PROs—California Medical Review, Inc., San Francisco, California; Crescent County Foundation for Medical Care, Naperville, Illinois; and Professional Foundation for Health Care, Inc., Tampa, Florida.

Chapter 2

HCFA Needs to Better Assure That Claims Processing Errors Are Resolved

HCFA's oversight of Medicare claims processing does not adequately assure that intermediaries resolve claims errors detected by computer edits in the health insurance master record. As of July 1987, intermediaries had accumulated a backlog of claims with over 2 million unresolved questions raised by these edits. We reviewed payments totaling $1,212,410 by three intermediaries where HCFA's computer edits had identified 277 possible claims processing errors and found 73 overpayments of $272,011 and 7 underpayments of $5,468. The remaining 197 cases generally (1) involved errors that had no effect on the payments reviewed or (2) were incorrectly classified as having errors due to problems in the process of reporting claims data to HCFA.

In mid-1987, HCFA instituted procedures that should help to prevent future increases in the error backlog. These new procedures, however, do not provide for follow-up on intermediary actions to resolve any of the numerous errors detected before fiscal year 1988 by master record edits. Also, they do not provide for any follow-up for duplicate claims and some other types of errors. In addition, the procedures need to be modified to assure that intermediaries give priority to correcting errors that may result in significant overpayments.

The master record with its computer edits is one of HCFA's major controls over the payment of benefits by both intermediaries and carriers. The master record, however, has not been included under FMFIA as an area for evaluation by program managers.[1] Thus, the claims resolution weaknesses discussed in this chapter were not included in the Secretary of HHS's fiscal year 1987 FMFIA report to the President and the Congress.

Magnitude and Nature of Claims Processing Errors

For the year ended November 30, 1987, HCFA identified what it believed to be errors in about 3.5 percent of the 67.5 million paid claims received from intermediaries. This included errors in about 8 percent of the 11.9 million claims for inpatient hospital services.

Before entering claims data into the master record, the data are subjected to about 160 computer edits that detect two categories of errors: In the first category, more information is needed before the claim can pass various edits and be entered into the master record. These claims

[1] In our report on HHS's second-year implementation of FMFIA (GAO/HRD-86-9, Nov. 8, 1985), we noted that HCFA needed better controls over Medicare and Medicaid payments and made recommendations that would lead to improved controls. Consistent with our recommendations, HCFA subsequently began to develop a plan to build internal control elements into its monitoring programs. However, as of June 1988, it had not yet included in its plan the master record and its computer edits.

are recorded in a suspense file called the returned to intermediary (RTI) file. A claim record stays in this file until the intermediary returns a revised claim. If the revised claim can pass the various edits, the erroneous claim data are deleted from the RTI file and the revised claim data are entered into the master record.

The second category of errors includes duplicate claims and cases involving claims with errors such as (1) wrong Medicare identification numbers and (2) incorrect calculations of the number of days of hospitalization. These errors, which are not placed in the RTI file, are automatically corrected; the corrected data are entered into the master record, and the corrective action is reported to the intermediary so that it can adjust its records and resolve any payment discrepancies.

We identified for more indepth analysis 13 edits that detect errors of the type that raise significant payment questions.[2] Twelve edits resulted in returning claims to intermediaries for resolution and one resulted in uncovering duplicate payments. The effects of the 13 types of errors are discussed in the following sections.

Errors in RTI File

Table 2.1 shows that the backlog of pending RTI claims increased every quarter from January to October 1986. In November 1986, there was a decrease of about 3.8 million largely because HCFA purged errors relating to payments for hospital outpatient services. The backlog then increased every quarter through July 1987. It then decreased slightly for the periods ended October and December 1987, possibly reflecting HCFA's increased emphasis on resolving RTI claims errors. The backlog then dropped markedly for the period ended March 31, 1988, primarily due to HCFA's purge of over a million errors it had detected before fiscal year 1988.

[2]HCFA personnel agreed that the 13 edits we identified raise significant payment questions but indicated that other edits also had the potential for identifying significant payments questions. These included edits to detect (1) admission to a skilled nursing facility more than 30 days after hospital discharge without an adequate explanation, (2) incorrect DRG calculations, and (3) services overlapping a period when the beneficiary was entitled to services from a health maintenance organization.

Table 2.1: Pending RTI Claims at Selected Dates From January 1986 to March 1988

Date	Number of pending RTI claims
January 31, 1986	3,936,695
April 30, 1986	5,112,618
July 31, 1986	5,418,503
October 31, 1986	5,469,835
November 30, 1986	1,697,380
January 31, 1987	1,766,591
April 30, 1987	2,063,283
July 31, 1987	2,222,592
October 31, 1987	1,954,948
December 31, 1987[a]	1,934,586
March 31, 1988	434,014

[a]Used December 1987 rather than January 1988, data because, after December 1987, HCFA reports from which the data were taken included only errors identified in fiscal year 1988.

As of November 30, 1986, the 12 RTI-related edits we reviewed detected about 543,000 of the 1.7 million RTIs and over $1.6 billion of the $3.5 billion in the inventory of claims questioned.[3]

To evaluate intermediary action to resolve the errors and determine the effect of the errors on payments, we selected 108 examples of questionable claims raised by the 12 computer edits for the three intermediaries we reviewed. Our review at the intermediaries, however, disclosed that only 3 of the 108 questionable claims had been resolved; the other 105 were pending intermediary action to resolve them. This did not give us a sufficient indication of whether these claims involved significant payment questions. Therefore, at one intermediary, we obtained estimates of overpayments and underpayments for 29 of the 105 unresolved questionable claims in our initial selection on claims processed by that intermediary. At another intermediary, we evaluated an additional 27 questionable claims the intermediary had resolved between January 1986 and May 1987. The effect on payments involving the 59 questionable claims (3 resolved and 29 unresolved from our initial selection, and 27 additional questionable claims) is summarized in table 2.2.

[3]HCFA provided us with RTI files that listed $3.45 billion in payments with 1,269,020 unresolved errors as of Nov. 30, 1986. However, HCFA reports showed that there were 1,697,380 unresolved RTI errors as of that date.

Table 2.2: Types, Universe, and Sample of HCFA-Detected Claim Errors That Raise Significant Payment Questions[a]

	Universe		Claims reviewed by GAO						
			Total		No payment	Overpayments		Underpayments	
Type of error	Number	Amount (millions)	Number	Amount	effect	Number	Amount	Number	Amount
No record of beneficiary entitlement to types of services claimed	2,862	$1.3	5	$21,069	2	3	$14,778	•	•
Services are shown after benefits stopped	1,697	2.8	6	61,202	1	5	38,737	•	•
Services are shown after the patient died	23,904	45.4	11	78,908	7	4	311	•	•
Master record shows health maintenance organization pays for services	36,125	23.8	7	59,068	2	5	18,699	•	•
Part A cash deductible was underapplied	389,556	1,283.2	2	32,974	1	1	400	•	•
Part B deductible has not been met	14,967	2.2	2	4,932	0	2	150	•	•
Full inpatient reimbursement days have been overutilized[b]	26,229	151.3	5	117,316	0	4	14,137	1	$369
Error in full coverage days	24,199	72.0	5	59,214	1	1	192	3	1,846
Error in coinsurance days	8,541	24.4	4	32,497	0	3	2,643	1	1,453
Error in lifetime reserve days	1,414	4.8	2	11,828	0	1	943	1	1,400
Error in lifetime psychiatric days	1,277	3.5	3	14,918	1	2	1,542	•	•
Claim overlaps a previously accounted claim	12,068	30.6	7	63,815	2	4	13,624	1	400
Total	**542,839**	**$1,645.2**	**59**	**$557,738**	**17**	**35**	**$106,156**	**7**	**$5,468**

[a]Commenting on this table, HHS stated that, when the provisions of catastrophic health insurance legislation are implemented, lesser amounts of payment errors will be identified by some of the edits listed in the table. HHS cited as examples inpatient days and lifetime reserve days which will no longer be applicable. HHS's comment, while correct, does not negate a major purpose of the table, which was to illustrate the significance of potential overpayments that exist in the RTI backlog purged by HCFA.

[b]Medicare provides full reimbursement (less a deductible of up to $520) for up to 60 days of hospitalization, after which time part of the reimbursement becomes the responsibility of the patient.

The 59 questionable claims were not randomly selected and, therefore, are not projectable to the universe of questions raised by the 12 master record computer edits. In addition, the results of the resolution actions are not necessarily representative of the amounts of overpayments and underpayments included in the questioned claims. Of the resolution actions we examined, however, 71 percent showed errors amounting to 20 percent of the payments made for the claims questioned by the edits. Thus, the corrective actions indicate that the large number of questionable claims identified by the master record edits include erroneous payments that, if adjusted, could significantly reduce Medicare costs.

Duplicate Payment Errors

In general, HCFA identifies those claims that have the same dates of service as duplicate claims. HCFA does not maintain a separate file on the

duplicate claim errors that it corrects. However, we extracted 20,285 claims involving payments of $58,872,259 from HCFA's routine transaction files for the 3-month period ended June 30, 1987, which it had identified as duplicate claims. Of these claims, 1,425 involved payments of $3,257,775 by the three intermediaries we reviewed.

To determine whether the duplicate claims identified by HCFA actually resulted in duplicate payments, we randomly selected 218 duplicate claims involving payments of $654,672 that were made by the three intermediaries covered by our review. We found that 38 of the 218 claims were paid in duplicate, resulting in $165,855 in overpayments (see table 2.3). The remaining 180 cases were not duplicate payments, but the existence of such cases indicated the need for improved procedures for communicating claims data from intermediaries to HCFA.

Table 2.3: Duplicate Payments Identified by HCFA and Sample Reviewed by GAO for Three Intermediaries

			Claims reviewed by GAO				
	Universe		Total		No payment	Overpayments	
Intermediary	Number	Amount	Number	Amount	effect	Number	Amount
A[a]	558	$1,172,992	110	$240,364	105	5	$17,925
B	744	1,681,050	61	231,303	37	24	114,672
C	123	403,733	47	183,005	38	9	33,258
Total	**1,425**	**$3,257,775**	**218**	**$654,672**	**180**	**38**	**$165,855**

[a]Of the 105 claims at Intermediary A where we found no payment effect, 33 were hospice claims totaling $64,505, which were not duplicate payments. These hospice claims were listed as duplicate because of a duplication in the intermediary's reporting process for this type of claim to HCFA. The problem was corrected in October 1987.

Although our sample represents all of the HCFA-identified duplicate payments by the three intermediaries covered by our review, it cannot be considered representative of duplicate payments nationwide. However, 17 percent of the claims we examined showed payment errors of 25 percent of the payment amounts for those claims. Thus, the findings indicate that correcting the errors could result in the recovery of substantial amounts of duplicate payments.

Intermediaries Not Adequately Resolving Master Record-Identified Errors

For the 108 claims we selected from HCFA's RTI file of unresolved claims as of November 30, 1986, the intermediaries had not acted to resolve 105 by late May 1987. For the three intermediaries we reviewed, the claims in the RTI file had remained unresolved after HCFA had notified them of the errors for an average of 440 days for Intermediary A, 450 days for Intermediary B, and 528 days for Intermediary C. Further, HCFA information showed that nationwide, the average length of time claims had been in the RTI inventory was 393 days as of April 30, 1987. In addition, the intermediaries generally were not acting to recover overpayments identified by HCFA's master record edit for duplicate claims.

Intermediary officials attributed their lack of action to resolve questions raised by HCFA's master record edits to reasons such as

- adding the higher priority Medicare Secondary Payer program without increasing staff,[4]
- resolving questions raised by the edits was not a performance evaluation category under CPEP (see pp. 22 to 24),
- curtailing error correction processing while implementing improvements to their computer systems, and
- insufficient funding.

Inadequate Action to Resolve Errors in RTI File

For the 105 cases selected from HCFA's RTI file that the intermediaries had not resolved at the time of our review, the majority had remained unresolved for 9 months or more (see table 2.4).

Table 2.4: Age of Unresolved RTI Claims With HCFA-Identified Errors Reviewed by GAO

	Elapsed time between identification by HCFA and resolution or time of GAO review			
Intermediary	Less than 9 months	9-18 months	18 months	Total
A	21	48	0	69
B	3	19	7	29
C	0	4	3	7
Total	**24**	**71**	**10**	**105**

Intermediary officials said that RTI errors often occurred because of problems in their claims processing systems. One intermediary official

[4]Automotive insurers or other liability insurance plans may be liable for payment of bills for some services provided to Medicare beneficiaries. In recent years HCFA has implemented requirements to establish secondary payer liability. When such liability is established, intermediaries are required to adjust provider payments to the extent of the liability.

cited an instance where a master record computer edit (the underapplication of the part A cash deductible) had raised 21,653 questions during 1 year. Research by the intermediary indicated that the inpatient deductibles had been correctly applied. However, information on the deductibles had not been reflected on claims data sent to HCFA because of a design defect in the intermediary's system. The defect was corrected and RTI claims with errors caused by this defect were reprocessed.

Inadequate Action to Resolve HCFA-Identified Duplicate Payments

Of the 38 duplicate payments we found in our test of 218 claims that HCFA had identified as duplicate claims, 22 had not been resolved by the intermediaries. Although the other 16 had been resolved, the resolutions appeared to result basically from chance rather than from use of computer edits specifically designed to identify such errors. For example, we followed up on the five duplicate payments that Intermediary C had resolved. We were advised by an intermediary official that the resolutions did not result from duplicate claim notices from HCFA. Rather, the official said the resolutions resulted from inquiries from beneficiaries and hospitals and actions during routine claims processing. We believe that a systematic follow-up by the intermediaries on HCFA's notices of duplicate claims could have resulted in the resolution of all payments flagged by HCFA's duplicate claims edit.

The number and amount of duplicate payments in our sample for each of the three intermediaries is shown in table 2.5.

Table 2.5: Duplicate Payments Detected by HCFA's Duplicate Claim Edit and Reviewed by GAO

	Resolved		Unresolved		Total	
Intermediary	Number	Amount	Number	Amount	Number	Amount
A	0	•	5	$17,925	5	$17,925
B	11	$52,500	13	62,172	24	114,672
C	5	12,658	4	20,600	9	33,258
Total	**16**	**$65,158**	**22**	**$100,697**	**38**	**$165,855**

The 38 duplicate payments shown in table 2.5 occurred primarily because processing personnel bypassed duplicate payment edits without adequately assuring that the claims had not been paid. Intermediary officials explained that their claims processing systems have edits to prevent duplicate payments. However, they said that some types of payment adjustments require the use of special codes to bypass the edits so

their automated claims processing systems would not reject the adjustments. At Intermediary A, where we identified the fewest duplicate payments, an official said that their system shows an error code to flag most types of claims where edits are bypassed, thus alerting processing personnel to conduct checks that prevent most duplicate payments. However, at the other two intermediaries, where we found 33 of the 38 duplicate payments, we found no indication of checks to detect errors in making adjustments when using bypass codes.

HCFA Not Adequately Assuring Corrective Actions

Although our review focused on internal controls over payments by intermediaries, HCFA follows the same process for recording into the master record payments by carriers for services by physicians and other noninstitutional providers, as it does for recording payments by intermediaries. In addition, the objectives of the CPEP for carrier operations are similar to those for intermediary operations. Therefore, our comments on HCFA's actions to assure resolution of questions raised by master record computer edits generally apply to payments by both carriers and intermediaries.

HCFA's fiscal year 1987 CPEP instructions for evaluating intermediaries and carriers did not provide for follow-up on resolution of errors detected by master record edits. After we informed HCFA of the lack of corrective actions being taken on errors that it had identified, it initiated a claim error cleanup project. The project involved

- providing intermediaries and carriers additional funding in June 1987 to improve their systems,
- follow-up contacts with intermediaries on their progress in resolving errors and improving their systems, and
- adding instructions to CPEP to specifically deal with carriers' and intermediaries' timeliness in resolving errors.

These recent additions should prevent future increases in the RTI backlog. However, as discussed below, they may result in intermediaries giving priority to correcting the easy-to-resolve errors. In addition, CPEP does not provide for follow-up on (1) cases detected by master record edits before fiscal year 1988, and (2) duplicate claims and other errors not in the RTI files.

While the recent CPEP additions should help to prevent future increases in the total RTI backlog, they will not likely result in a substantial number of resolutions of cases in the backlog that existed at the time of

our review. The additions provide that HCFA's Bill Received and Returned Report be used in evaluating intermediary timeliness in resolving errors in the RTI file. In March 1988, HCFA purged this file of about 75 percent of the 1.9 million-case backlog. Therefore, according to HCFA personnel, the 434,014 claim errors pending in the March 31, 1988, Bill Received and Returned Report included only those errors detected after fiscal year 1987.

If intermediaries resubmit at least 80 percent of the RTI claim errors within 90 days,[5] HCFA's fiscal year 1988 CPEP will give the intermediaries passing scores. Such a requirement encourages intermediaries to focus on quantities of errors whether or not the errors raise significant payment questions. One of the three intermediaries we reviewed had begun to respond to HCFA's cleanup project for claims errors. An intermediary official said the intermediary was concentrating on the types of corrections that would resolve a large number of errors at one time. The intermediary gave us examples of 5 types of error corrections, only 2 of which were included in the 13 types of errors we had identified as raising significant payment questions. These 2 were of the types that raised less significant payment questions than did most of the other 11 types included in our review. The 20 corrections the intermediary gave us netted reductions in benefit payments of $755, less than 1 percent of payments totaling $91,397.[6] In contrast, according to this intermediary's evaluation, the 30 RTI claims we selected (included in table 2.2) netted reductions totaling $68,302, about 16 percent of payments totaling $431,322.

We recognize that resolution of even those errors that do not raise significant payment questions is necessary to assure that data in the master record are current, complete, and accurate. We believe, however, that resolution of errors raising significant payment questions should be given priority.

In addition, the 1988 CPEP evaluations of master record-identified errors limits the evaluations to RTIs, thus excluding the numerous errors that HCFA identifies every year that are not recorded in the RTI files. Many of

[5]CPEP allows points for various performance levels. For example, no points are allowed if less than 60 percent of RTIs are returned to HCFA within 90 days; 4.9 points (considered a passing score for the element on timeliness in returning RTIs) are allowed if 80 percent to 84.9 percent are returned within 90 days; and 7 points are allowed if at least 97.5 percent are returned within 90 days.

[6]This $755 in corrections involved payment increases of $1,364 in a total of 14 claims, a decrease of $2,119 in 1 claim, and no change in payments for the other 5 claims.

these errors involve inconsistent information (such as more days of hospitalization than are indicated by the discharge and admission dates reported on a claim) that does not affect payment amounts for the claims in question but might cause errors in paying future claims. Some of the errors, however, involve duplicate claims, and we found that most of these were not resolved by the three intermediaries we reviewed. Intermediary officials explained that they have been faced with increasing workloads and indicated that, while HCFA evaluates them on other categories of error resolution, they are not evaluated on resolving duplicate payments.

Conclusions

By July 1987, a backlog of over 2 million questions raised by HCFA's master record edits about claims paid by the nation's intermediaries had accumulated, and intermediaries had resolved only 3 of 108 questionable claims we selected from HCFA's file of questionable claims raised by the edits. HCFA took action after we brought the problem to its attention. This action could have resulted in slight decreases in the backlog but, in March 1988, HCFA purged most of the 2 million questionable claims from its file.

The unresolved questionable claims raise questions about the propriety of benefit payments. The corrective actions on claims we reviewed indicate that, if master record-identified errors are resolved, Medicare costs could be significantly reduced.

Recent actions by HCFA should increase assurance that RTI claims corrections are made in the future. These actions, however, (1) do not focus on the types of errors that raise significant payment questions, (2) do not include follow-up on the numerous questionable claims raised by the edits before fiscal year 1988, and (3) do not include follow-up on duplicate claims and other questionable claims not recorded in HCFA's RTI files. We believe HCFA's monitoring programs should assure that intermediaries resolve all questionable claims raised by the master record edits, but that special attention should be given to resolving duplicate claims and other cases that raise significant payment questions.

We also believe that HCFA should evaluate whether carriers take adequate and timely corrective actions to resolve errors detected by master record edits because

- significant numbers and amounts of errors in payments by intermediaries were detected by these edits but were not corrected in an adequate and timely way and
- the same process is used for detection and follow-up on errors in paid claims reported by carriers as for those reported by intermediaries.

In addition, we believe that material weaknesses in internal controls are shown by the inadequate actions of (1) intermediaries to resolve questions raised by the master record edits and (2) program managers to evaluate the effectiveness of intermediaries' actions. Thus, these weaknesses and planned corrective actions should be included in the Secretary's fiscal year 1988 FMFIA report to the President and the Congress.

Recommendations to the Secretary of HHS

To better assure the correction of errors detected through HCFA's master record edits, we recommend that the Secretary of HHS require the Administrator of HCFA to

- include all errors detected by master record computer edits in its unresolved claims file (RTI file) until intermediaries confirm that they have been fully resolved;
- add requirements to CPEP that will assure that intermediaries (1) resolve those types of errors that raise significant payment questions and (2) correct systems weaknesses that allow the errors to occur; and
- revise CPEP to assure follow-up on actions by intermediaries to resolve errors purged from the RTI file in early 1988, especially those that raise significant payment questions.

We also recommend that the Secretary of HHS require the Administrator of HCFA to evaluate the adequacy and timeliness of corrective actions taken by carriers in resolving errors detected by master record edits.

In addition, we recommend that the Secretary include in his fiscal year 1988 FMFIA report to the President and the Congress a discussion of (1) the material weaknesses in internal controls involving inadequacies in correcting Medicare payment errors identified by HCFA's master record edits and (2) the actions planned or taken to correct such weaknesses.

Agency Comments and Our Evaluation

HHS did not agree with most of our recommendations, but said it would consider our recommendation on carriers resolving errors detected by the master record edits. Other technical comments provided by HHS have been included in the report.

Include All Errors in the RTI File

HHS said that, given the limited resources of the intermediaries, HCFA should not include all errors in the RTI file. HHS said, however, it would review the categories of errors to ascertain optimum use of the RTI file and look into alternative techniques that will give reasonable assurance that significant errors are in fact resolved.

We recognize that various techniques might be used to assure that the errors are resolved, and these should be explored. However, we continue to believe that all errors detected by the master record computer edits should be included in the RTI file until resolved. The RTI file is (1) a system already developed and in use to maintain a record of errors and (2) a means of maintaining accountability for errors identified by the master record edits that the intermediaries are already required to resolve. Use of the file, with appropriate test checks, could provide reasonable assurance that the errors are resolved.

HHS also stated that all errors cannot be included in the RTI file because many do not require correction or other action by the intermediary, such as automatic adjustments, which require no action by the intermediary. If no action was required by the intermediary, we would agree that the errors should not be included in the RTI file. However, action by the intermediary was still needed on the one type of automatic adjustment we reviewed. This type of adjustment involved duplicate claims that were detected by the master record edit.

Focus on Significant Payment Questions

HHS did not agree with our recommendation that emphasis should be placed on dollar value in resolving RTIs. HHS said that high-dollar RTIs usually require more time and effort to resolve and that placing proper emphasis on resolving the highest volume of RTIs will capture the high-dollar RTIs. HHS also said that (1) the design of the edits for detecting claims processing errors constitutes de facto prioritization of errors that raise significant payment questions, and that it was currently in the process of reviewing and improving its edit design; (2) HCFA's fiscal year 1988 CPEP includes a standard involving the Intermediary Systems Testing Project, whereby HCFA tests each intermediary's system for weaknesses that would ordinarily result in an RTI; and (3) HCFA is designing a standard consistency edit module for distribution to all intermediaries for January 1, 1989, implementation.

HHS's actions should improve the effectiveness of the RTI program. However, we continue to believe that the Medicare program would benefit from a mechanism for assuring the prompt resolution of errors involving

significant payment questions because our review indicated that the intermediaries concentrated on resolving the errors with less significant payment questions. Concentration by the intermediaries on these types of errors is understandable because, under CPEP, ratings are based on the volume of errors resolved, not their dollar significance.

Assure Resolution of Purged Errors

HHS stated that the RTI files were purged selectively after giving careful consideration to the alternatives and that some intermediaries with high error volumes were required to work backlogs.

While HCFA did exclude the records of a few intermediaries from its initial purge of errors with dates of service before January 1987, it subsequently purged all errors that were identified before fiscal year 1988. Thus, the only RTIs on which HCFA is rating the intermediaries were identified after September 30, 1987.

HHS also stated that records from the purge are no longer available and it may not be possible to recreate the file from historical records.

Our discussions with the HCFA official who had carried out the records purge indicated that HCFA normally retains a copy of purged files for a year. We verified that a copy of the purged files discussed in our report is available at HCFA. Since the purged files involve over a million questionable Medicare payments, we believe HCFA should direct the expeditious resolution of these questionable payments.

Assure Resolution of Errors by Carriers

HHS stated that it would consider the implications of our recommendation on evaluating the adequacy and timeliness of corrective actions taken by carriers in resolving errors detected by master record edits, and that it would come to a decision shortly. We continue to believe that HCFA should assure that these errors are appropriately resolved.

Include Discussion of Weaknesses in the Secretary's FMFIA Report

HHS did not believe the problems we identified constitute material weaknesses that should be reported under FMFIA. We disagree. As of November 1986, there were 542,839 pending RTI claims (over 30 percent of the total RTI backlog) with errors that raise significant questions about $1.6 billion in payments. Our review of 59 such errors, involving payments of $557,738, showed that about 20 percent of this amount was actually paid in error. In addition, cases involving duplicate claims were not recorded in the RTI file and 25 percent of the amount of these claims we

examined was actually paid in error. HCFA was not following up on any of these errors and few were being resolved.

Subsequent to the start of our review, HCFA implemented procedures for following up on errors in the RTI file but (1) made 75 percent of the backlog not subject to follow-up by purging the RTI file, and (2) still does not have procedures for following up on duplicate claims and other types of errors not recorded in the RTI file. We therefore believe that a weakness in internal controls continues to exist and that, due to the significant amount of payments that is going unresolved, the weakness is material.

Chapter 3

Need to Effectively Use SuperPRO to Assure the Appropriateness of PRO Medical Review Determinations

We reviewed the results of SuperPRO evaluations for the three PROs in our review for periods of about 15 months ending in 1986. We projected that incorrect PRO determinations resulted in

- 43,000 hospital admissions that, according to available documentation, were not necessary;[1]
- overpayment of some claims by $30 million and underpayment of some by $28 million because the claims were classified into inappropriate DRGs;[2] and
- the PROs failing to detect 12,000 cases where the quality of care did not meet minimum acceptable professional standards.[3]

Despite these findings, HCFA does not make effective use of SuperPRO's evaluations to identify and correct systemic problems that result in erroneous PRO determinations. In addition, (1) payment adjustments are not made to reflect the correct determinations when SuperPRO evaluators show that PRO decisions were erroneous and (2) HCFA medical reviewers evaluate many PRO-reviewed claims that are also subject to evaluations by SuperPRO.

SuperPRO's review of PRO determinations, in our opinion, is one of HCFA's major controls over intermediary payments and the quality of care provided to beneficiaries. SuperPRO's review, however, has not been included as an area for evaluation by program managers under FMFIA. Thus, the lack of corrective action on SuperPRO's findings were not included in the Secretary's fiscal year 1987 FMFIA report to the President and the Congress.

[1] At the 95-percent confidence level, we estimate that the three PROs failed to detect between 37,000 and 49,000 instances, with payments between $82 million and $112 million or about 43,000 instances with payments of about $97 million. In these instances, both SuperPRO and the PROs agreed that, based on available documentation, the hospital admissions were not medically necessary. There was insufficient information to determine the offsetting cost for providing necessary services to these beneficiaries on an outpatient basis.

[2] At the 95-percent confidence level, we estimate that the three PROs failed to detect incorrect DRG assignments, resulting in between 17,000 and 26,000 overpayments of between $22 million and $39 million or about 21,000 overpayments of $30 million; and between 14,000 and 21,000 underpayments of between $19 million and $38 million or about 17,000 underpayments of $28 million.

[3] At the 95-percent confidence level, we estimate that the three PROs failed to detect between 9,000 and 16,000 cases of poor quality care or about 12,000 cases.

Size and Nature of Erroneous Determinations

SuperPRO evaluates claims reviewed by PROs to determine if PROs (1) make appropriate DRG determinations, (2) identify medically unnecessary hospital admissions, and (3) identify claims for which beneficiaries were provided poor quality care. About every 6 months each PRO submits universe data to SuperPRO on claims reviewed. SuperPRO randomly selects about 400 claims, reviews copies of hospital records and other medical data for each claim selected, evaluates PRO comments on claims believed to involve erroneous PRO decisions, and reports on review results to HCFA. SuperPRO's procedures and criteria for conducting the evaluations are essentially the same as those used by PROs in performing the reviews.

In addition to providing HCFA with lists of instances where PRO determinations were judged erroneous, SuperPRO reports we reviewed included comparisons of the percentages of SuperPRO-identified claims with the percentages of PRO-identified claims. These claims involved (1) payments made under the wrong DRGs, (2) referrals that should have been made to a physician for a determination on the medical need for a hospital admission, (3) medically unnecessary hospital admissions, and (4) patients who receive substandard care.

SuperPRO evaluates the nation's PROs in cycles. Each of the first three cycles for the PROs we reviewed covered decisions they made over time periods of 4 to 6 months. As of January 1988, HCFA had compiled nationwide data on four SuperPRO evaluation periods. The data showed that SuperPRO consistently identified about four times as many DRG classification errors, about four times as many instances of questionable hospital admissions, and more than twice as many cases of poor quality care as did the PROs (see table 3.1). HCFA data also show that SuperPRO nonphysician reviewers referred about five claims to physicians for review of admission necessity determinations for every three claims referred by PRO nonphysician reviewers.

Table 3.1: Comparison of Medical Review Results of SuperPRO and the Nation's PROs

Type of determination	Percent of problems detected for SuperPRO review period			
	I	II	III	IV
DRG errors				
PROs	5.4	5.0	5.0	5.9
SuperPRO	14.6	14.9	16.5	16.6
Referrals for physician review				
PROs	9.9	9.3	10.6	10.8
SuperPRO	17.0	15.8	18.0	18.1
Unnecessary admissions				
PROs	2.6	2.9	2.7	2.1
SuperPRO	10.6	10.7	12.0	9.6
Poor quality care				
PROs	0.8	1.0	1.8	3.7
SuperPRO	3.0	2.0	5.0	8.5

The three PROs we reviewed provided data on claims where they agreed or disagreed with SuperPRO judgments for the first three reporting periods. Our calculations of the percentages of cases in which the three PROs agreed and disagreed with SuperPRO's findings are shown in table 3.2.

Table 3.2: Percent of Instances Where PROs Agreed and Disagreed With Final SuperPRO Decisions

Type of determination	Agreements for SuperPRO review period			Disagreements for SuperPRO review period		
	I	II	III	I	II	III
DRG coding	74	84	82	26	16	18
Referrals for physician review	37	56	65	63	44	35
Unnecessary admissions	43	60	71	57	40	29
Poor quality care	58	95	65	42	5	35

The above percentages are based on questions raised by SuperPRO in evaluating 3,515 SuperPRO-reviewed claims selected from about 504,000 PRO-reviewed claims. Our estimates of 43,000 unnecessary hospital admissions—38,000 inappropriate DRG classifications and 12,000 cases of poor quality care that went undetected—are based only on those claims for which PROs agreed with SuperPRO's findings.

The estimates of payment errors and undetected cases of poor quality care are not a complete indicator of the magnitude of the problems. The estimates are only relevant to about 17 percent of the inpatient hospital claims paid by intermediaries and subject to review by SuperPRO. For the

83 percent of claims not subject to review by SuperPRO but paid by the intermediaries, we could not make statistically valid estimates of the amount of inappropriate payments or quality-of-care problems. This was because all cases reviewed by PROs are not subject to review by SuperPRO[4] and because of the way PROs identify claims for review. In identifying claims for review, PROs review small random samples of all claims processed by intermediaries as well as all or larger percentages of the types of cases believed to be abnormally problematical.

Information on the severity levels of the problems included in table 3.2 as poor quality care was not included in SuperPRO reports for the first three reporting periods, the only reports available to us at the time of our review. Subsequent reports did contain information on the severity of patient risk due to quality-of-care problems. For the three PROs we reviewed, following is a summary of information from the final SuperPRO reports on the severity of quality-of-care problems identified for the 1,187 cases reviewed by SuperPRO in the fifth reporting period. These SuperPro reports identified

- 58 cases where the potential for patient risk was of a serious nature, as compared with 28 cases identified by the PROs.
- 3 cases where actual reversible or minor harm was done to the patient, as compared with 1 case identified by the PROs.
- 9 cases where irreversible or significant harm was done to the patient, as compared with 2 cases identified by the PROs.

SuperPRO Review Results Not Effectively Used to Identify and Correct Systemic Problems

Although HCFA's contract with SuperPRO indicates that SuperPRO results will be used as a mechanism to improve the quality of PRO reviews, HCFA makes little use of these results in assuring that the causes of erroneous PRO decisions are identified and corrected. Rather, HCFA makes its own medical reviews (see pp. 35 and 36). HCFA's Central Office has provided no instructions to regional offices on how the results are to be used in evaluating PRO operations. In addition, (1) SuperPRO's review and reporting process does not include a mechanism for resolving the many cases of disagreement between SuperPRO and PROs and (2) at the time of our

[4]HCFA instructs SuperPRO not to evaluate PRO preapproval or denial of hospital admissions or procedures, or PRO reviews undertaken for readmissions within 2 weeks of a previous discharge, transfers of beneficiaries from PPS to non-PPS units, admission denials by hospitals, or cases that involve an unusually high amount of cost or number of inpatient days for the DRG into which the claims were classified.

review, SuperPRO did not communicate to PROs its specific reasons for disagreeing with PRO decisions. As a result, cases where SuperPRO and PROs disagreed usually went unresolved.

Limited Use of SuperPRO Results

HCFA's contract with SuperPRO states that

"HCFA will review these [SuperPRO] reports and when indicated, will notify PROs of problems identified by this [the SuperPRO] effort. PROs will be instructed to correct those problems. Follow-up reviews will be conducted by HCFA to ensure compliance."

A HCFA official said that SuperPRO results are also to be used for promoting more consistent application of the medical criteria used by PROs when reviewing claims from hospitals.

Notwithstanding the intended use of SuperPRO results, significant use has not been made of the SuperPRO reviews to correct systemic problems. A HCFA official noted only one specific instance of a systemic weakness that was corrected as the result of SuperPRO evaluations. In evaluations of about 400 hospital admissions during late 1984 and early 1985, SuperPRO found that one PRO had allowed 39 admissions for cataract surgery. SuperPRO believed the surgery could have been performed on an outpatient basis. As a result, the HCFA official said that HCFA required this PRO to change its policy of allowing hospital admissions in such cases.

Our review also showed that only one of the three HCFA regional offices we evaluated was attempting to use SuperPRO review results. HCFA's San Francisco Regional Office had established minimum acceptable error rates for the PROs under its oversight. It requested the PRO we reviewed in that region to respond to high error rates noted in SuperPRO's reports in the areas of (1) payments made under the wrong DRGs, (2) referrals that should have been made to a physician for a determination on the need for a hospital admission, and (3) unnecessary hospital admissions. For DRG errors, this PRO responded with a description of its training plans for medical reviewers, noting that the reviewers would continue to receive updates on how to code medical conditions. For the other two types of errors, the PRO replied that, where it agreed with SuperPRO (it agreed in about half of the cases), the cases were directed back to the PRO claims reviewers to advise them of their errors. However, the subsequent SuperPRO report continued to show substantial differences between the results of the PRO's and SuperPRO's review.

HCFA officials said that the SuperPRO concept is relatively new and they are continuously seeking ways to make better use of SuperPRO results in assessing PRO performance. They cited a recent addition to their PRO Monitoring Protocol and Tracking System as an illustration of their effort to make more extensive use of SuperPRO results. In a section on management internal controls, PROMPTS now requires HCFA regional offices to assess the adequacy of PROs' corrective actions where the results of SuperPRO evaluations indicate deficiencies in the accuracy and consistency of physician advisors' decisions. However, the officials recognized that HCFA lacked guidelines on the relative roles and responsibilities of SuperPRO, the HCFA regional offices, and the PROs on use of SuperPRO case evaluation results in identifying deficiencies in PRO operations.

Procedures Lacking to Resolve Differences Between PROs and SuperPRO

SuperPRO's review and reporting process, as established by HCFA, is of limited usefulness for improving the quality of PRO reviews because there is no mechanism for resolving differences for those numerous claims where PROs disagree with the final SuperPRO decisions. Also, at the time of our review, SuperPRO did not explain the basis for its judgments where they differed from those of PROs.

Our evaluation of three SuperPRO reporting periods for the three PROs reviewed showed that there were 98 DRG assignment disagreements and 39 quality-of-care disagreements with no indication of SuperPRO's reasons for those disagreements. Another 264 disagreements involved the necessity of admissions. Although SuperPRO's reports did show that 217 of the admission necessity disagreements involved cases where SuperPRO disagreed with the PROs' medical review criteria or their application of the criteria, the reports did not specify why SuperPRO disagreed or how the existing criteria should be changed.

PRO personnel informed us that without adequate information on why SuperPRO disagrees with their medical decisions they are not in a position to revise their criteria or otherwise improve their operations. As a result, PRO personnel said similar disagreements with SuperPRO were likely to occur. However, HCFA officials informed us that SuperPRO had recently changed its reports to include an explanation for its continued disagreement with PROs' medical decisions.

Need to Refocus Efforts of HCFA and SuperPRO Medical Reviewers

SuperPRO's results are not used in conducting assessments under PROMPTS. Rather, PROMPTS instructions provide that medical personnel in HCFA's regional offices evaluate cases reviewed by the PROs. These types of evaluations duplicate to a significant extent evaluations performed by SuperPRO. By the same token, HCFA might better use its regional office medical personnel to assure that SuperPRO evaluation results are effectively used to identify and correct weaknesses in PRO operations that result in erroneous decisions.

HCFA officials said they had not used SuperPRO results in PROMPTS assessments in the past because the PRO and SuperPRO concept was new (the initial PRO contracts were awarded in 1984, and the initial SuperPRO contract was awarded in 1985). The officials said they wanted to conduct their own evaluations to assure that they had current and reliable information on which to base their assessments of the PROs. However, the officials recognized that SuperPRO has now become established as an available resource of information for assessing PRO performance. They said they are continuously considering ways to make more effective use of SuperPRO results in assessing PRO performance.

HCFA officials also said they need to assess PROs on all of the types of reviews they perform but that SuperPRO conducts only certain types of evaluations. HCFA instructs SuperPRO not to evaluate PRO preapproval or denial of a hospital admission or procedure, or PRO reviews undertaken for (1) readmission within 2 weeks of a beneficiary's previous discharge; (2) transfer of a beneficiary from a PPS to non-PPS units; (3) determinations by hospitals that patients no longer require hospital-level care; and (4) cases, known as outliers, that involve an unusually high cost or number of inpatient days for the DRG into which the claims were classified. A HCFA official said that SuperPRO was excluded from evaluating such types of reviews because this would be too costly or time consuming, or because of other reasons.

The types of cases that are subject to both HCFA regional office and SuperPRO evaluation include claims reviewed by PROs (1) for certain specific reasons (such as having been classified under a DRG where the risk of misclassification is unusually high) and (2) in responding to the contract requirement with PROs that all cases have at least a 3-percent chance of being selected for review. Although in the past, the majority of cases were of the types that were subject to both HCFA regional office and SuperPRO evaluation, subsequent PROMPTS changes resulted in reduced percentages of these types of cases. However, for assessments conducted in fiscal year 1987, after the PROMPTS changes were implemented,

about 45 percent of 530 cases evaluated by HCFA in the three PROs we reviewed fell into categories that also made them subject to SuperPRO evaluation.

PROMPTS medical evaluations are conducted on a regional basis by a limited number of personnel assigned to or under contract with HCFA regional offices. In contrast, SuperPRO uses a large variety of specialists in conducting its evaluations and, as a national medical review organization, is in a position to have a perspective on standard medical practices throughout the nation. Therefore, SuperPRO may be in (1) a better position to perform evaluations of cases than is the medical staff of a HCFA regional office and (2) a good position to provide some perspectives on the performance of PROs. By the same token, because PROMPTS assessments by HCFA regional offices involve more aspects of PRO operations than do medical evaluations by SuperPRO, the HCFA regional office medical staffs appear to be in a good position to assure that the causes of SuperPRO findings involving individual PROs are identified and corrected.

For these reasons, it appears that the time of the medical staffs in HCFA regional offices would be more effectively used in assuring that SuperPRO findings are adequately assessed, rather than evaluating cases that are also subject to SuperPRO evaluation.

PROs Should Reconsider Claims Where Erroneous Decisions Are Indicated

SuperPRO and other evaluations of PRO medical determinations identified numerous claims where PROs agreed they made inappropriate review decisions that affected payments to institutions. PROs, however, do not direct intermediaries to make adjustments for such claims. Because these claims result in both excessive payments and underpayments to institutions, it would be more equitable to the Medicare program and the provider institutions if PROs were to require intermediaries to make payment adjustments where appropriate.

PROs agree that they reached incorrect conclusions in many of the review decisions noted by SuperPRO. For SuperPRO evaluations over periods totaling about 15 months and ending in 1986, table 3.3 shows the number of claims where the three PROs we reviewed agreed that they had made erroneous review decisions. Failure to correct the errors resulted in hundreds of thousands of dollars in inappropriate payments. In addition, HCFA regional offices and others, such as the HHS Inspector General, have identified instances where PROs made inappropriate review decisions.

Table 3.3: Claims Reviewed by SuperPRO Over Periods Totaling About 15 Months and Ending in 1986, Where Three PROs Agreed They Made Erroneous Review Decisions

Area of determination	Number of errors[a]	Amount of overpayments	Amount of underpayments
DRG errors	255	$202,880	$190,206
Unnecessary admissions	272	[b]	[b]
Total	**527**	**$202,880**	**$190,206**

[a]PROs agreed they made erroneous decisions on another 70 cases for which intermediaries were unable to provide information on the financial impact of the erroneous decisions.

[b]Payments for the 272 unnecessary admissions totaled $742,711. However, there was insufficient information to determine the offsetting cost for providing services to these beneficiaries on an outpatient basis.

HHS regulations, at 42 C.F.R. 466.96(a), provide that within 1 year of a claim, a PRO may review and deny payment and, thereafter, the PRO has an additional year to reconsider such denial. Furthermore, a PRO generally has up to 4 years to change its decision where a reviewing error or additional information on the patient's condition is found. There is no time limitation for changing a decision where fraud or abuse is found.

Despite PROs' authority to reconsider medical review decisions, HCFA's contract with SuperPRO indicates that any determinations by SuperPRO will not affect Medicare payments. HCFA officials explained that SuperPRO was initially intended to be an education tool for PROs and was not intended for use in payment considerations. Further, they believed that they could not require the PROs to change their decisions.[5] However, the officials said that HCFA does not preclude PROs from reconsidering cases and directing intermediaries to adjust payments to reflect the correct review decisions.

Conclusions

Our estimates based on SuperPRO reports indicate that PROs, by making erroneous review decisions, are (1) allowing millions of dollars in questionable payments to go uncorrected and (2) failing to detect numerous instances of poor quality care. We believe that HCFA needs to establish a process to assure that the causes of the errors are identified and corrected. Such a process should include

[5]Section 1154(a)(2) of the Social Security Act provides that medical determinations of the PRO are ordinarily conclusive for purposes of determining whether benefits should be paid. A beneficiary, practitioner, or provider who is dissatisfied with a determination made by the PRO is entitled to reconsideration and under certain conditions to further administrative reviews and judicial review.

- the establishment of guidelines on the relative roles and responsibilities of SuperPRO, HCFA regional offices, and PROs on use of SuperPRO case evaluation results in identifying deficiencies in PRO operations,
- procedures for attempting to resolve PROs' disagreements with SuperPRO's final review decisions, and
- encouragement of PROs to direct intermediaries to make payment adjustments where appropriate in cases where SuperPRO or other evaluators disclose erroneous PRO review decisions.

We believe that while more extensive use of SuperPRO results could increase program costs through, for example, more use of contract physicians by HCFA regional offices to evaluate PROs' responses to SuperPRO case findings, a substantial amount of the increased costs might be offset through more effective use of existing medical staffs in HCFA regional offices. Rather than evaluating cases that are also subject to evaluation by SuperPRO, the staffs could focus on assuring that SuperPRO findings are adequately assessed and resolved.

In addition, we believe that the inadequate use of SuperPRO review results to identify and correct systemic problems in the PROs' medical determinations is a material internal control weakness. Thus, the weakness and planned corrective action should be included in the Secretary's fiscal year 1988 FMFIA report to the President and the Congress.

Recommendations to the Secretary of HHS

To have greater assurance that PROs are performing effective medical reviews, we recommend that the Secretary of HHS require the Administrator of HCFA to

- develop guidelines on the relative roles and responsibilities of SuperPRO, HCFA regional offices, and PROs in determining why differences between SuperPRO and PRO review decisions are occurring; identifying actions that PROs should take to reduce the differences; and tracking PRO corrective actions to assure that the differences are reduced to appropriate levels.
- reevaluate the relative roles of the medical staff of SuperPRO and HCFA regional offices; eliminate from PROMPTS instructions the requirement that regional office medical review staff conduct routine case evaluations in those areas covered by SuperPRO; and use SuperPRO results as a primary basis for monitoring the quality of PRO medical reviews.

Also, to better assure that provider payments adequately reflect appropriate medical determinations, we recommend that the Secretary of HHS

require the Administrator of HCFA to (1) encourage PROs to direct payment adjustments where appropriate in cases where erroneous review decisions are disclosed by SuperPRO or other evaluators and (2) incorporate into the PROMPTS a requirement for regional offices to assess the PROs' performance in changing review decisions that subsequent evaluations show were erroneous.

In addition, we recommend that the Secretary, in his fiscal year 1988 FMFIA report to the President and the Congress, include a discussion of the material internal control weakness—ineffective use of SuperPRO review results to identify and correct systemic problems in PROs' medical review determinations—and planned corrective action.

Agency Comments and Our Evaluation

HHS generally agreed with our recommendations for better assuring that PROs are performing effective medical reviews. It disagreed, however, with our recommendations involving oversight of PROs' action to direct payment adjustments where erroneous review decisions were made. It also disagreed that the problems we identified should be included in FMFIA reports to the President and the Congress. Following is our evaluation of HHS's comments.

Better Assure That PROs Are Performing Effective Reviews

Responding to our recommendations aimed at making more effective use of SuperPRO results in assuring the quality of medical reviews by PROs, HHS indicated that it has been moving toward this goal. HHS stated that in the last year, it has required two corrective action plans on the basis of SuperPRO findings.

HHS also cited the following initiatives under consideration to address the differences between SuperPRO and PRO review results: (1) the development of an advisory group of HCFA central and regional office, PRO, and SuperPRO representatives to provide perspectives for use in developing guidelines for interpreting and analyzing SuperPRO findings; (2) the preparation of plans to address issues in the next SuperPRO contract that have resulted in part from disagreements between PROs and SuperPRO; and (3) the shifting of the focus of the PROMPTS medical review component to include SuperPRO review results. In addition, HHS stated that it is reevaluating the relative roles of the SuperPRO and medical staff at HCFA regional offices and is considering initiatives to minimize duplicative reviews.

We believe that HHS's actions and the initiatives that are under consideration, if appropriately developed and implemented, should provide greater assurance that PROs perform effective medical reviews.

Better Assure That Payments Reflect Appropriate Medical Decisions

In response to our recommendations to better assure that provider payments adequately reflect appropriate medical determinations, HHS said that it cannot require PROs to reopen their medical decisions but they may do so at their own option. However, HHS indicated that (1) the PROs are held accountable for carrying out their responsibility and (2) PROMPTS provides for the evaluation of PROs' responses to SuperPRO findings through assessment of the PROs' internal quality assurance system. HHS stated that PROs failing to correct problems are terminated or not renewed on a noncompetitive basis.

Because PROs were not directing adjustments in those cases where they agreed they made erroneous decisions, we believe that PROMPTS should specifically require assessments of PROs' performance in changing review decisions that subsequent evaluations show to be erroneous.

Include Weaknesses in Secretary's FMFIA Report

HHS did not believe that there was a material internal control weakness in the use of SuperPRO evaluation results that needed to be included in the Secretary's FMFIA report. HHS stated that the SuperPro program is relatively new and the evaluations were initially intended as an educational tool rather than an internal control technique. HHS also stated it was strongly considering incorporating the results of SuperPRO evaluations in PROMPTS monitoring and final evaluation protocols.

Regardless of their initial intent, SuperPro evaluations have shown that PROs have not detected significant numbers of unnecessary hospital admissions, allowed payments for numerous incorrectly categorized diagnoses, and failed to detect many cases where the quality of care did not meet minimum acceptable quality-of-care standards. We believe that many of these problems could be prevented if HHS made more effective use of the results of SuperPro findings to correct the underlying conditions that led to these erroneous decisions. We also continue to believe that a discussion of this weakness and the planned action to correct it should be included in the Secretary's FMFIA report.

Other Comments

HHS raised questions concerning some of our projections of SuperPRO evaluation results. HHS stated that it was not certain the three PROs we

selected are truly representative of all PROs, and it questioned the accuracy of extrapolated dollar amounts in our report or whether the projections should have been reported at all. Because we also are not certain whether the three PROs reviewed were truly representative of all PROs, we did not make nationwide projections. Rather, we confined our projections to the three PROs in our review. Our statisticians used a widely accepted computer program and other standard statistical techniques for making dollar and other projections. We believe that the projections serve their intended purpose of showing that substantial amounts of inappropriate payments could be identified through more effective PRO reviews.

HHS also questioned the statement in our draft report that only about 17 percent of the inpatient hospital claims paid by the intermediaries were reviewed by the PROs. HHS's observation is correct. We should have stated that only about 17 percent of the inpatient hospital claims paid by the intermediaries were subject to review by SuperPro rather than saying "reviewed by the PROs." The report has been corrected.

In commenting on costs for unnecessary hospital admissions, HHS stated that we should have estimated the offset amount it would have cost to provide outpatient care to beneficiaries that should not have been hospitalized. We initially tried to develop this type of cost information but were not successful because of questions about whether cost information available to us was applicable to the cases in question and whether the documentation we had on the cases included all of the information necessary to make meaningful estimates. As a result, we disclosed the lack of outpatient cost information on pages 29 and 37 of this report.

HHS also stated that there should be an analysis of the severity levels of the problems included in table 3.2 as poor quality care. We agree. However, information for such an analysis was not included in SuperPRO reports for the first three reporting periods. These reports were the only ones available to us at the time of our review. Since the fifth SuperPRO reporting period included information on severity levels and is now available, we added a discussion of severity levels for that period on page 32.

Need to Strengthen Existing Internal Controls

HCFA should require intermediaries to report on the effectiveness of edits they use to help identify claims for which services are not medically necessary. The number and types of medical edits used by the intermediaries we reviewed varied substantially, and they did not accumulate information on the effectiveness of the various edits. Under the Medicare part B program, HCFA requires carriers to report information on the effectiveness of their medical need edits in processing payments and has used the information as a basis for requiring all carriers to use those edits found to be effective. Using the edits, carriers disallowed $67.4 million in claims during the first two quarters of fiscal year 1987.

In addition, PROs are not required to report their case review results to SuperPRO until after they are notified of the cases selected for SuperPRO review. PROs, therefore, have the opportunity to reconsider and change their initial decisions before SuperPRO's evaluation. This internal control weakness raises questions about the validity of using SuperPRO results as a measure of PRO performance, and could be resolved by having the PROs report all of their review results before SuperPRO selects cases for review.

These internal control weaknesses were not discussed in the Secretary of HHS's fiscal year 1987 FMFIA report to the President and the Congress. The Secretary should consider reporting them in 1988, along with planned actions to correct the weaknesses.

Need to Assure Intermediaries Use Effective Edits for Detecting Unnecessary Medical Services

HCFA's instructions to intermediaries highlight situations where services provided to beneficiaries by institutions may not be medically necessary and generally prohibit payments for such services. To identify services that may not be medically necessary, the three intermediaries we reviewed had developed a series of edits in areas such as occupational therapy, inhalation therapy, cardiac rehabilitation, and pulmonary rehabilitation. For example, one intermediary had developed edits to identify claims for cardiac rehabilitation where treatment exceeds a total of 100 days or a 12-month period, or where charges exceed certain dollar parameters. Detailed reviews are made of claims detected by the edits and decisions are made on whether to pay, deny, or reduce them. Such edits can be excellent control techniques.

The number and types of medical need edits used varied substantially among the intermediaries we reviewed, and there was no information on their usefulness. Intermediary officials said that operating instructions from HCFA do not require them to collect such information.

The operating instructions for carriers[1] are different. Carriers are required to report to HCFA on the effectiveness of edits used in identifying claims for unnecessary services. In another review,[2] we used information reported by the carriers to show that Medicare could save millions of dollars through nationwide implementation of effective edits for detecting unnecessary medical services. This review of nine carriers showed that some were using edits not used by others. In February 1983, we reported that the Medicare part B program could have saved millions had all nine carriers been using 20 edits found to be effective. We recommended that HCFA compare medical need edits used by all carriers and require those most effective to be used nationwide. Subsequently, HCFA did this and its data show that, for the first two quarters of fiscal year 1987, the edits HCFA requires saved $67.4 million. We believe that savings can also be achieved by applying medical need edits to intermediaries.

Need to Assure Integrity of Data Submitted to SuperPRO

SuperPRO performs independent medical evaluations of a statistical sample of claims for which PROs have already made medical determinations. These evaluations could constitute a major technique of internal control to guard against the payment of inappropriate claims or the payment of inappropriate amounts for valid claims. After SuperPRO selects claims for evaluation, however, PROs have the opportunity to re-review the claims and change their initial determinations. This raises questions about the use of SuperPRO evaluation results as a measure of PRO performance, thus limiting the evaluations' value as a potential internal control technique.

HCFA contracts with SuperPRO to evaluate cases reviewed by PROs to determine if the PROs (1) made appropriate DRG determinations, (2) determined whether a patient should have been admitted to the hospital, and (3) identified quality-of-care issues. For periods of about 6 months, universe data on claims paid by intermediaries, which were reviewed by the PROs, are submitted by PROs to SuperPRO. PROs are not required to include their review results in the universe data, and two of the three PROs we evaluated excluded review results from the data submitted.

SuperPRO randomly selects a sample of cases from the PRO-submitted universe data. A PRO is given 10 days to submit its review results for these

[1]HCFA has carrier contracts with 8 commercial insurance companies and 27 Blue Shield plans.

[2]Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services (GAO/HRD-83-16, Feb. 8, 1983).

cases, and 45 days to submit medical information necessary for SuperPRO's evaluations. Then, SuperPRO reviews the information and reports to HCFA on cases where it believes inappropriate PRO review decisions were made.

The three PROs we evaluated reviewed an average of 60,000 cases every review cycle, of which SuperPRO selected about 400 for evaluation. Some PRO personnel told us that when compiling information for SuperPRO, they (1) note review decision errors that they could easily change and (2) would be able to reconsider all 400 cases selected for SuperPRO evaluation in the time available to them to provide review results for those cases. Neither SuperPRO nor HCFA has controls in effect to preclude or detect changes in review results made by PROs while responding to SuperPRO's request for data on cases selected for evaluation.

This internal control problem could be solved by requiring PROs to include their review decisions in the universe data submitted to SuperPRO. The PROs we reviewed submitted their universe data for SuperPRO sample selection by magnetic tape. PRO personnel told us that their review decision data are stored on the same magnetic tape files from which the universe data for SuperPRO are extracted. They said that when SuperPRO requests universe data, they could easily extract their review decision data and include it with the universe data submitted. SuperPRO could then use the PRO review decisions reported in the universe data when comparing its decisions with those of the PROs, thus eliminating the internal control weakness we found in the SuperPRO evaluation process.

Conclusions

After analyzing reports from carriers on the effectiveness of computer edits used to detect unnecessary medical services, HCFA identified certain edits for all carriers to use when processing claims for services by physicians and other noninstitutional providers. HCFA has required nationwide implementation of the edits, saving the Medicare program millions of dollars every year. We believe that additional savings could be realized by (1) requiring intermediaries to report similar information on their computer edits for detecting unnecessary services and (2) using the information to identify edits effective for all intermediaries.

The integrity of the SuperPRO evaluation process—as an internal control technique for guarding against payment of inappropriate claims and payment of excessive amounts—is weakened by allowing PROs the opportunity to reconsider and reverse their review decisions after they are notified of the cases selected for SuperPRO evaluation. This internal

control weakness could be corrected by requiring (1) PROs to include their review decisions in the universe of data submitted for SuperPRO sample selection and (2) SuperPRO to use these data as a basis for comparing its decisions with those of the PROs.

Also, consideration should be given to including a discussion of these internal control weaknesses, along with planned actions for correcting them, in the Secretary's fiscal year 1988 FMFIA report to the President and the Congress.

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to require

- intermediaries to report on the results of edits used for detecting unnecessary medical services and implement those edits demonstrated to be effective and
- (1) PROs to report their case review decisions to SuperPRO concurrently with their universe of cases reviewed and (2) SuperPRO to use this information in comparing its review findings to those of the PROs.

We also recommend that the Secretary of HHS, in his fiscal year 1988 FMFIA report to the President and the Congress, consider

- including as internal control weaknesses HCFA's lack of (1) a mechanism for assessing medical need edits used by intermediaries to identify the most effective edits for all intermediaries and (2) controls to assure the integrity of data submitted for SuperPRO evaluation and
- reporting the planned corrective actions on these weaknesses.

Agency Comments and Our Evaluation

HHS stated that it is taking alternative measures to those we recommended on edits to detect unnecessary medical services to assure the integrity of data submitted to SuperPRO. However, it either did not respond to or indicated disagreement with our other recommendations.

Edits for Detecting Unnecessary Medical Services

HHS stated that HCFA already requires intermediaries to report on the effectiveness of edits used to identify questionable services for medical review. However, the reports to which HHS referred do not include information on edits used by the intermediaries in denying the claims. It is this type of information that is necessary to evaluate the effectiveness of intermediaries' medical need edits.

HHS advised us that in July 1988, HCFA sent a memorandum to all intermediaries soliciting criteria that they had found to be effective for identifying questionable services for medical review. HHS stated that, in fiscal year 1989, these criteria will be evaluated and criteria with national applicability will be tested. Implementation will be mandated for edits found to be cost effective. We believe that HHS's planned action has the potential for identifying productive edits in use but that continued monitoring of the edits is necessary as new edits are identified, or as program needs or other conditions change.

Reporting of PRO Case Review Decisions

In commenting on our recommendation that PROs report case review decisions to SuperPRO concurrently with their universe of cases reviewed, and that this information be used in comparing PRO and SuperPRO review findings, HHS indicated that, beginning next year, SuperPRO case selections would be made by HCFA from a database that already includes the results of the PRO reviews. According to HHS, there will be no possibility that this process could be compromised. This change should resolve the potential data integrity problem we identified.

Consider Including Weaknesses in Secretary's FMFIA Report

HHS believes that PROs are not presently altering case review decisions and that it has corrected the weakness that allows PROs the opportunity to change their review results before submitting them to SuperPRO. Therefore, HHS does not believe that the problem should be reported as an internal control weakness in the fiscal year 1988 FMFIA report. However, whether corrected or not, FMFIA requires the reporting of weaknesses that are identified as making a program vulnerable to waste, fraud, and abuse. Thus, we believe that HHS should reconsider including this weakness in the Secretary's FMFIA report.

HHS did not respond to our recommendation to consider including as a weakness in its next FMFIA report HCFA's lack of a mechanism for assessing intermediaries' use of medical need edits. We continue to believe that this type of problem should be considered for inclusion in FMFIA reports.

Appendix I

HCFA's Programs for Monitoring Payments by Intermediaries

Programs for monitoring Medicare intermediaries			
Program	**Objective**	**Responsible organization**	**Output**
1. CPEP	To enhance the quality of intermediary performance.	Bureau of Program Operations and regional offices	Annual contractor evaluation reports, which are used to identify poor performers for possible termination or other contract actions.
2. Quality Evaluation of Settlements under TEFRA/PPS[a]	To measure intermediary performance in reviewing, auditing, adjusting, and settling hospital cost reports.	Bureau of Quality Control and regional offices	Regional office reports to the Bureau of Quality Control and the intermediaries. Results are used in CPEP.
3. Home Office Quality Evaluation of Settlements under TEFRA/PPS	To evaluate intermediary performance in auditing home office cost statements of multi-institution providers.	Bureau of Quality Control and regional offices	Regional office reports to the Bureau of Quality Control and the intermediaries.
4. Home Health Agency Reimbursement Review	To measure intermediary performance on reviewing, adjusting, and settling home health agency cost reports.	Bureau of Quality Control and regional offices	Regional office findings are reported to the intermediary and the Bureau of Quality Control. Results are used in CPEP.
5. Intermediary Systems Testing Project	To evaluate the performance of intermediary claims processing systems.	Bureau of Program Operations and regional offices	Data from intermediaries to HCFA on test claims processed by intermediaries' systems.
6. Test of Intermediary Prospective Payment Settlements	To evaluate intermediary performance in reviewing, auditing, adjusting, and settling prospective payment cost reports.	Bureau of Quality Control and regional offices	Regional office reports to the Bureau of Quality Control and the intermediaries. Results are used in CPEP.
7. Medical Coding Monitor Review	To monitor the quality of medical code reporting for inpatient hospital claims for the Medicare program.	Bureau of Data Management and Strategy	Quarterly reports from intermediaries to HCFA. Results are used in CPEP.
8. Reviews of intermediaries' report of benefit savings	To monitor contractor compliance with TEFRA for audit and medical claims review.	Bureau of Program Operations and regional offices	Reports from intermediaries to HCFA on the costs and savings from audit and medical review. Results reported to the Congress and used in CPEP.
Program for monitoring PRO activities			
9. PROMPTS	For regional office to monitor PRO's performance.	Health Standards and Quality Bureau and regional offices	Regional office reports to the Health Standards and Quality Bureau. Results are used in evaluations of PROs.

[a]The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248) placed limits on total inpatient operating costs. Hospitals excluded from PPS are subject to TEFRA limits.

Note: We revised this appendix to reflect HHS's comments on our draft report.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

AUG 29 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Need to Strengthen Controls Over Payments by Medicare Intermediaries"

Overview

GAO reviewed the effectiveness of the internal controls that program managers use for ensuring that services provided by hospitals and other institutions are of acceptable quality and that payments to them are: accurate; for patients entitled to benefits; and for services covered by Medicare. According to GAO, the Health Care Financing Administration (HCFA) has not ensured that intermediaries resolve potential claims processing errors identified by master record computer edits. GAO believes that resolution of errors identified by master record edits could significantly reduce Medicare costs.

In addition, using the results of SuperPRO evaluations covering 3 of 44 Peer Review Organizations (PROs) for periods of about 15 months ending in 1986, GAO projected that the 3 PROs had allowed millions of dollars in overpayments and underpayments. GAO also explains that HCFA does not effectively use SuperPRO findings to identify and correct systemic problems which allow significant numbers of errors to occur. Finally, while the three intermediaries GAO reviewed had developed various computer edits to identify claims for services that may have been unnecessary, the number and types of edits varied substantially and the intermediaries had not analyzed the usefulness of each of the edits.

We would like to point out that we are not certain that the three PROs selected are truly representative of all PROs, and we question the accuracy of extrapolated dollar amounts in the report or whether the projections should have been reported at all. The report also discusses substantial payments made for unnecessary hospital admissions while stating that the costs of providing necessary services to these beneficiaries on an outpatient basis are unavailable. We believe these outpatient costs should be estimated using average amounts to provide a basis for comparison of this offset. Finally, the report states that only about 17 percent of the inpatient hospital claims paid by intermediaries were reviewed by the PROs. This is interesting since this is a retrospective study from the first Scope of Work where the PROs reviewed 40-45 percent of such claims.

GAO Recommendation

To better assure the correction of errors detected through HCFA's master record edits, we recommend that the Secretary of HHS require the Administrator of HCFA to:

-- include all errors detected by master record computer edits in its unresolved claims file (RTI file) until intermediaries confirm that they have been fully resolved;

Department Comment

We believe that, given limited resources available to intermediaries, HCFA should be selective regarding the pending of all errors until intermediaries confirm that they have been fully resolved. For certain types of errors, it would be too simple for intermediaries to send back a positive signal automatically, and such a signal would not necessarily indicate corrective action. We will, however, review the categories of errors to ascertain optimum use of the pending file. We will also look into alternative techniques, such as HCFA reviews, that will give reasonable assurance that significant errors, which are not pended, are in fact resolved.

All errors detected by the master record computer edits cannot be included in the RTI file. Many edits do not require correction or other action by the intermediary. An example of these would be automatic adjustments. An automatic adjustment edit is included on the Bill Error Report to notify the intermediary of a correction that was made by HCFA internally. There is no further action required of the intermediary. To include these edits in the RTI file would serve to confuse the monitoring and evaluation of intermediary RTI processing.

GAO Recommendation

-- add to the Contractor Performance Evaluation Program (CPEP) requirements that will assure that intermediaries: (1) resolve those types of errors that raise significant payment questions; and (2) correct systems weaknesses that allow the errors to occur; and

Department Comment

The FY 1988 CPEP includes a standard for measuring the accuracy of intermediary processing systems. By utilizing the Intermediary Systems Testing Project (ISTP), HCFA tests each intermediary's system for weaknesses which would ordinarily result in an RTI. The ISTP is a program of test claims specifically designed to identify deficiencies in an intermediary's system.

We do not agree that emphasis should be placed on dollar value. Clearly, it is of paramount importance to maintain a high degree of accuracy in the Health Insurance Master Record, particularly with respect to the new catastrophic health benefit. High dollar RTI's are usually more complex and require more time and effort to resolve. We believe that proper emphasis on resolving the highest volume of RTI's will capture the high dollar RTI's. However, we believe that the design of the edits constitutes a de facto prioritization of errors which raise significant payment questions. We are currently in the process of reviewing and improving edit design.

Furthermore, HCFA has been correcting system weaknesses that allow errors to occur. Intermediaries were given funds in June of 1987 to begin this process, and numerous formal and informal follow-up contacts have been made with regional offices and intermediaries. We are currently designing a standard consistency edit module for distribution to all intermediaries for January 1, 1989 implementation.

GAO Recommendation

-- revise the CPEP to assure follow-up on actions by intermediaries to resolve errors purged from the RTI file in early 1988, especially those that raise significant payment questions.

Department Comment

The force-posting which took place in early 1988 was done selectively after careful consideration of alternatives. Some intermediaries with high error volumes were required to work backlogs. The force-posting was done to reduce workload to manageable size so that standards could be enforced in FY 1988 and future years. FY 88 standards are stricter than those for FY 87, and those for FY 89 will be still stricter.

Records from the purge are no longer available. It may not be possible to recreate the file from historical records. Individual intermediaries may have retained relevant data in their history files. However, we have no way of assuring that the data would be available from the source.

GAO Recommendation

That the Secretary of HHS require the Administrator of HCFA to evaluate the adequacy and timeliness of corrective actions taken by carriers in resolving errors detected by master record edits.

Department Comment

We will consider the implications of this recommendation and come to a decision shortly.

GAO Recommendation

That the Secretary include in his fiscal year 1988 Federal Managers' Financial Integrity Act (FMFIA) report to the President and the Congress a discussion of: (1) the material weaknesses in internal controls involving inadequacies in correcting Medicare payment errors identified by HCFA's master record edits; and (2) the actions planned or taken to correct such weaknesses.

Department Comment

We do not believe a report under the FMFIA is appropriate since the "weaknesses" discussed are not material in nature.

GAO Recommendation

To have greater assurance that Peer Review Organizations (PROs) are performing effective medical reviews, we recommend that the Secretary of HHS require the Administrator of HCFA to:

-- develop guidelines on the relative roles and responsibilities of the SuperPRO, the HCFA regional offices and the PROs in determining why differences between SuperPRO and PRO review decisions are occurring; identifying actions that PROs should take to reduce the differences; and tracking PRO corrective actions to assure that the differences are reduced to appropriate levels; and

Department Comment

We have been aware of the significant differences between the PRO and SuperPRO findings in many cases, and a number of initiatives to address this situation are already under consideration:

-- development of an advisory group of HCFA central office and regional office staff, PRO and SuperPRO representatives to provide a forum for the discussion of SuperPRO "issues" and provide additional perspectives for use in the development of such guidelines for interpretation and analysis; and

-- inclusion of specific SuperPRO findings in the PRO evaluation process along with the PRO Protocol and Tracking System (PROMPTS) and other PRO contract performance assessments.

In the first two contract cycles, SuperPRO has been used primarily as an educational tool for the PROs in identifying areas of their performance that require attention under their own internal quality assurance mechanisms. For example, SuperPRO findings have been a valuable asset to the PROs in the identification of training needs for their personnel.

Part of the disagreement rate between the PROs and SuperPRO can be explained as legitimate issues with respect to local conditions. For example, there are certain procedures which SuperPRO believes can always be provided most appropriately on an ambulatory basis. Individual PROs, however, are evaluating the actual delivery of services in some cases in areas where no suitable outpatient facilities are available. The statute requires that PROs apply local standards of medical practice, and SuperPRO clearly does not and cannot apply a different standard in different States. We plan to address these issues in the next SuperPRO contract.

We have used HCFA medical staff, as appropriate, to analyze the disagreement rates and identify those differences in medical opinion that lead to disagreements between PRO and SuperPRO findings.

Corrective action plans (CAPs) are developed by the PROs and regional offices in response to identified contract performance deficiencies. The development and implementation of the CAPs are carefully tracked by both HCFA central and regional offices. We are presently developing an automated CAPs tracking system to reduce the administrative burden on HCFA staff and allow a more thorough evaluation of CAP effectiveness. In the last year, there have been two CAPs issued with respect to SuperPRO activities and findings.

During the first Scope of Work we recognized that there were problems with the medical review determinations being made by the PROs. As a result, 25 of the first PRO contractors were not renewed. Additionally, in the second Scope of Work, we implemented the use of generic quality screens to identify potential quality of care problems that were not being satisfactorily addressed through PRO review.

GAO Recommendation

-- reevaluate the relative roles of the SuperPRO and medical staff of HCFA regional offices; eliminate from PROMPTS instructions the requirement that regional office medical review staffs conduct routine care evaluations in those areas covered by the SuperPRO; and use SuperPRO results as a primary basis for monitoring the quality of PRO medical reviews.

Department Comment

We are currently reevaluating these relative roles and are considering initiatives to minimize duplicative reviews and address the disagreement rate of review determinations.

In addition, we are considering shifting the focus of the PROMPTS medical review component to include SuperPRO review results.

GAO Recommendation

That the Secretary of HHS require the Administrator of HCFA to: (1) encourage PROs to direct payment adjustments where appropriate in cases where erroneous review decisions are disclosed by SuperPRO or other evaluators; and (2) incorporate into the PROMPTS a requirement for regional offices to assess the PROs' performance in changing review decisions that subsequent evaluations show were erroneous.

Department Comments

Section 1154(a)(2) of the Social Security Act specifically states that PRO determinations constitute the conclusive determination for purposes of payment under Title XVIII on the issue of whether services were medically necessary. We believe that PROs may reopen their decisions at their own option but cannot be required to do so.

This does not mean that PROs are not held accountable for carrying out their responsibilities. Our PROMPTS' monitoring and final evaluation protocols are designed to identify problems in PRO performance and initiate appropriate corrective action. PROs that failed to substantially carry out the requirements of their contracts consistent with efficient administration of the program are either terminated or not renewed on a noncompetitive basis. This was demonstrated during the first PRO contracting cycle. PROs that did not meet their contractual requirement were identified and terminated. In addition, 25 PROs were found not to have performed at a high enough level to warrant noncompetitive renewal.

As to the second part of the recommendation, the PROMPTS currently provides for the evaluation of PROs' responses to SuperPRO findings through the assessment of the PROs' internal quality assurance system. Also, as stated above, our primary emphasis has been placed on PROs correcting identified problems in bill review on a prospective basis. PROs that fail to do this are either terminated or not renewed on a noncompetitive basis. This is currently provided for in the PROMPTS' monitoring and final evaluation protocols.

GAO Recommendation

That the Secretary, in his fiscal year 1988 FMFIA report to the President and the Congress, include a discussion of the material internal control weakness--ineffective use of SuperPRO review results to identify and correct systemic problems in PROs' medical review determination--and planned corrective action.

Department Comment

We do not believe that there was a material internal control weakness in the use of SuperPRO review results. Both the PRO program and the SuperPRO review mechanism are relatively new. SuperPRO review was initiated primarily to serve as an education tool for PROs to identify and correct deficiencies in their operation. It was also to be used by the regional offices to assist in the evaluation of PRO performance. We believe the SuperPRO mechanism has served this purpose. Based on our experience to date, we are strongly considering incorporating the results of SuperPRO reviews in the PROMPTS monitoring and final evaluation protocols.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to:

-- require intermediaries to report on the results of edits used for detecting unnecessary services and require all intermediaries to implement edits demonstrated to be effective; and

Department Comment

HCFA already requires intermediaries to report on the effectiveness of edits used to identify questionable services for medical review. The intermediaries submit quarterly reports of services and charges denied. In fiscal year 1987, intermediaries denied $242.9 million in medically unnecessary and noncovered services. They achieved savings of $5.60 to every $1.00 spent on medical review.

In July of 1988, a memorandum was sent to all intermediaries soliciting what they found to be effective criteria for identifying questionable services for medical review. In fiscal year 1989, these criteria will be evaluated and criteria with national applicability will be tested. Implementation will be mandated for edits found to be cost effective.

GAO Recommendation

-- require that: (1) PROs report their case review decisions to the SuperPRO concurrently with their universe of cases reviewed; and (2) the SuperPRO use the information in comparing its review findings to those of the PROs.

Department Comment

We do not believe that the PROs are presently altering case review decisions subsequent to selection for SuperPRO review, although we concede that this is a possibility. We share the concern that the integrity of the SuperPRO process be maintained. Under the third scope of work, SuperPRO case selections will be made by HCFA from a database that already includes the results of the PRO review. Therefore, there will be no possibility that the process could be compromised.

GAO Recommendation

That the Secretary of HHS, in his fiscal year 1988 FMFIA report to the President and the Congress, consider:

-- including as internal control weaknesses, HCFA's lack of: (1) a mechanism for assessing medical need edits used by intermediaries to identify the most effective ones for use by all intermediaries; and (2) controls to assure the integrity of data submitted for SuperPRO evaluation; and

-- reporting the planned corrective actions on these weaknesses.

Department Comment

We do not believe it is appropriate to report the lack of controls to ensure the integrity of data submitted for SuperPRO evaluations as an internal control weakness in the fiscal year 1988 FMFIA report. As stated above, we have no evidence and do not believe that PROs are altering case review decisions subsequent to selection for SuperPRO review. We have taken appropriate action in the third PRO contract cycle to prevent this from occurring.

Technical Comments

Now on p. 18.

Page 29, Table 2.2:-Some of the edits listed in the table will not produce the full savings projected by GAO when the provisions of the catastrophic legislation are implemented since they will no longer be applicable; e.g., inpatient days and lifetime reserve days.

Now on p. 20.

Page 32:-Intermediaries are required to operate in accordance with HCFA manual instructions. Intermediary manual instructions require timely and accurate processing of bills returned to the intermediary (RTI's) as errors. HCFA annually determines which contractor operations will be evaluated under CPEP. Many operations are included in 1 year and deleted in another. Often the evaluation of a particular contractor operation is reinstated in subsequent years. Such has been the case with the processing of RTI's.

In fiscal year (FY) 1981, the first year of CPEP, intermediaries were required to correctly resubmit RTI's with a passing level of 82 percent. In addition, the timeliness requirements of RTI processing were measured. The timeliness requirements were 50 percent of RTI's to be returned within 150 calendar days. In FY 1982 the performance levels were tightened to 90 percent for accuracy and 80 percent within 150 calendar days. Measurement of RTI processing was deleted in the FY 1983 CPEP and was not reinstated until the FY 1988 CPEP.

Regardless of whether the RTI process was included in CPEP, intermediaries were expected to process RTI's in a timely and accurate manner.

Now on p. 22.

Page 38:-CPEP standards are developed with input form HCFA central office and regional office technical personnel as well as contractor Technical Advisory Groups. The development process of the current standards included consideration of whether to focus on high dollar RTI's or on resolving the largest volume of outstanding RTI's. It was believed that high dollar RTI's are generally more complex and require more time and effort to resolve. It was also believed that it was of paramount importance to keep the HI Master Record as current, complete and accurate as possible. For these reasons, it was determined that the evaluation should focus on the resolution of all RTI's which would resolve the high dollar RTI's as well.

Now on p. 31.

Page 48:-The table and discussion concerning instances where PROs agree and disagree with SuperPRO findings make reference to concerns with respect to poor quality care. There should be an analysis and explanation of the severity levels of the quality problems being considered, and we feel that these quality concerns should be reported by severity levels in these instances.

Now on p. 35.

Page 54:-In the discussion of those types of cases not evaluated by SuperPRO, reference is made under item (3) to "Admission denials by hospitals." We believe that this reference should be to "hospital issued notices of noncoverage."

Now on p. 48.

Pages 70 and 71, Appendix 1 -- The following changes have occurred in the specified HCFA monitoring programs:

Program 1.-CPEP - The responsible components are the Bureau of Program Operations and the regional offices.

Program 2. - Hospital Prospective Payment System Bill Payment Review Program - This review program is no longer conducted.

Program 5. - Hospital Prospective Payment System Interim Payment Review Program - This review program is no longer conducted.

Program 10. - Reviews of Intermediaries Report of Benefit Savings - The responsible components are the Bureau of Program Operations and the regional offices.

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